Benefits: medical services or Medical Supplies that are:

1. Medically Necessary; and,
2. Pre-Authorized (when required under this Plan of Benefits or the Schedule of Benefits); and,
3. Included in this Plan of Benefits; and,
4. Not limited or excluded under the terms of this Plan of Benefits.

Benefits available under this Plan of Benefits are listed in Article III.

BlueCard® Program: a program in which all members of the Blue Cross and Blue Shield Association participate. Details of the BlueCard Program are more fully set forth in Article XII.

Brand Name Drug: a Prescription Drug that is manufactured under a registered trade name or trademark.

Certificate of Creditable Coverage: a document from a Group Health Plan or insurer that states that a Member had prior Creditable Coverage with that Group Health Plan or insurer.

Child: An Employee's unmarried child, whether a natural child, adopted child, foster child, stepchild, or child for whom an Employee has custody or legal guardianship and for whom the Employee provides at least fifty-one (51%) of the child's support. The term "Child" also includes an Incapacitated Dependent, a child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Group Health Plan. A child who is (or was) married will not be entitled to coverage, notwithstanding the termination of such marriage.

COBRA: the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto.

Coinsurance: the sharing of Covered Expenses between the Member and the Corporation. After the Member's Benefit Year Deductible requirement is met, the Corporation will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Member calculated as follows:

1. The percentage listed on the Schedule of Benefits; multiplied by,
2. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale; and,
3. Without regard to any Credit or allowance that may be received by the Corporation.

Concurrent Care Claim: an ongoing course of treatment to be provided over a period of time or number of treatments.

Continued Stay Review: the review that must be obtained by a Member (or the Member's representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Pre-Authorized as Medically Necessary. The Continued Stay Review process is outlined in Article III.

Contract: the Master Group Contract between the Corporation and the Employer.

Copayment: the amount specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

Corporation: Blue Cross and Blue Shield of South Carolina.

Covered Expenses: the amount payable by the Corporation for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

Credit(s): financial credits (including rebates and/or other amounts) to the Corporation directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager. Credits are used to help stabilize overall rates and to offset expenses and may not be payable to Employer or Members.

Reimbursements to a Participating Pharmacy, or discounted prices charged at Pharmacies, are not affected by these Credits. Any Coinsurance that a Member must pay for Prescription Drugs or Specialty Drugs is based upon the Allowable Charge at the pharmacy, and does not change due to receipt of any Credit by the Corporation. Copayments are not effected by any Credit.

Creditable Coverage: benefits or coverage provided under any of the following (each capitalized term as defined under HIPAA unless defined in this Plan of Benefits):

1. A Group Health Plan;
2. Health Insurance coverage;
3. Part A or Part B, Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10, United States Code (Armed Forces, Medical and Dental Care);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefit risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefit Plan);
9. A public health plan, including that of the United States Federal Government as well as that of a foreign country or its political subdivision; or
10. A health benefit plan under Section 5(e) of 22 U.S.C. 2504(e) (Peace Corps Act); or
11. A State Children's Health Insurance Program (SCHIP).

The term "Creditable Coverage" does not include coverage consisting solely of Excepted Benefits (as defined in this Article I).

Dependent: an individual who is:

1. An Employee's spouse; or

2. A Child under the age set forth on the Schedule of Benefits; or

3. A Child who is over the age set forth on the Schedule of Benefits, but who has not reached the age of termination of Benefits as set forth on the Schedule of Benefits, and is enrolled in and is attending (with attendance qualifying such Child as a full-time student under the rules of the institution) one of the following:

   a. High school; or

   b. An accredited or licensed school commonly recognized as a vocational, technical or trade school; or

   c. An accredited college or university; or

4. An Incapacitated Dependent.

The time period between graduation from high school and college entry, or between college graduation and graduate school entry, will be covered only if the Child has applied for admission beginning with the next regular semester immediately following graduation.

When requested by the Corporation, the Employee will furnish written proof (in the form of a certificate on the applicable school's letterhead) of items 3(a-c).

Discount Services: services (including discounts on services) that are not Benefits, but which may be offered to Members from time to time as a result of being a Member.

Disease Management Program: the voluntary disease management program provided by the Corporation. The Disease Management Program offers Members the opportunity to better understand and address their diagnosed conditions as well as other ancillary products or services depending on the nature of the condition.

Durable Medical Equipment: medical equipment that:

1. Can stand repeated use; and,

2. Is Medically Necessary; and,

3. Is customarily used for the treatment of a Member's illness, injury, disease or disorder; and,

4. Is appropriate for use in the home; and,

5. Is not useful to a Member in the absence of illness or injury; and,

6. Does not include appliances that are provided solely for the Member's comfort or convenience; and,

7. Is a standard, non-luxury item (as determined by the Corporation); and,

8. Is ordered by a medical doctor, oral surgeon, podiatrist, opthamologists or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment.

Emergency Admission Review: the review that must be obtained by a Member (or the Member's representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition. The Emergency Admission Review process is outlined in Article III.

Emergency Medical Care: Benefits that are provided in a Hospital emergency facility to evaluate and treat an Emergency Medical Condition.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or her unborn child, in serious jeopardy; or,

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

Employee: any employee of the Employer who is eligible for coverage, as provided in Article II of this Plan of Benefits, and who is so designated to the Corporation by the Employer.

Employer: the entity identified as the Employer in the Contract.

Employer's Effective Date: means the date the Corporation begins to provide services under the Master Group Contract.

Enrollment Date: means the date of enrollment in the Group Health Plan or the first day of the Probationary Period for enrollment, whichever is earlier.

ERISA: the Employee Retirement Income Security Act of 1974, and any amendments thereto.

Excepted Benefits: for purposes of HIPAA, the following insurance coverage that does not constitute Creditable Coverage:

1. Coverage only for accident, or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Worker's compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics;

8. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

9. If offered separately:

    a. Limited scope dental or vision benefits;

    b. Benefits for long-term care, nursing home care, home health care, community- based care, or any combination thereof;

    c. Such other similar, limited benefits as specified in regulations.

10. If offered as independent, non-coordinated benefits:

    a. Coverage only for a specified disease or illness;

    b. Hospital indemnity or other fixed indemnity insurance.

11. If offered as a separate insurance policy:

    a. Medicare supplemental health insurance (as defined under Section 1882(g)(l) of the Social Security Act);

    b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code;

    c. Similar supplemental coverage under a Group Health Plan.

Generic Drug: a Prescription Drug that has a chemical structure that is identical to and has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. Whether a Prescription Drug is a Generic Drug is determined by the Corporation's Pharmacy Benefit Manager.

Genetic Information: information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from a Member or family member of the Member. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

Grace Period: the thirty-one (31) day period for the payment of any Premium due, except the first Premium, during which time the Covered Expenses are paid by the Corporation, unless the Employer gives the Corporation written notice of intent to discontinue the Contract or this Plan of Benefits prior to the date the next Premium is due in accordance with the terms of the Contract. There is no Grace Period for the payment of the first Premium.

Group Health Plan: an employee welfare benefit plan to the extent that such plan provides health benefits to employees or their dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement, or otherwise. This Plan of Benefits is a Group Health Plan.

Health Status-Related Factor: information about a Member's health, including:

1. Health status;
2. Medical conditions (including both physical and mental illnesses);
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic Information;
7. Evidence of insurability (including conditions arising out of acts of domestic violence); or,
8. Disability.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, and any amendments and regulations thereto.

Home Health Agency: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

Home Health Care: part-time or intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Member in such Member's private residence.

Hospice Care: care for terminally ill patients under the supervision of a Physician, and is provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

Hospital: a short-term, acute care facility licensed as a hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Physicians, and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long-Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Members.

Identification Card: the card issued by the Corporation to a Member that contains the Member's identification number.

Incapacitated Dependent: a Child who is:

1. Incapable of financial self-sufficiency by reason of mental or physical disability; and,
2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. The Employee will furnish written proof of items (1) and (2) no later than 31 days after the Child's attainment of the maximum age listed on the Schedule of Benefits. The Employee will update items (1) and (2) each year after the two (2) year period following the maximum age listed on the Schedule of Benefits. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.

Investigational or Experimental Services: surgical procedures or medical procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgment of the Corporation not recognized as conforming to generally accepted medical practice, or the procedure, drug or device:

1. Has not received required final approval to market from appropriate government bodies; or,

2. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes; or,

3. Is not demonstrated to be as beneficial as established alternatives; or,

4. Has not been demonstrated to improve net health outcomes; or

5. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Late Enrollee: an Employee (or Dependent) who enrolls for coverage under this Plan of Benefits other than during:

1. The first period in which the Employee or Dependent is eligible to enroll if such initial enrollment period is a period of at least thirty (30) days; or

2. A special enrollment period (as set forth in Article II(E)(6)).

Lifetime Maximum: means the total Benefits (under this Group Health Plan) to which a Member is entitled during such Member's lifetime.

Long-Term Acute Care Hospital: means a long-term, acute care facility licensed as a long-term care hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Members (typically over an extended period of time) although such Members may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Members with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Long-Term Acute Care Hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Members.

Mail Service Pharmacy: a Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

Maternity Management Program: the voluntary program offered by the Corporation to Members who are pregnant.

Maximum Payment: the maximum amount the Corporation will pay for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion:

1. The actual charges made for similar services, supplies or equipment by Providers and filed with the Corporation during the preceding calendar year;

2. The Maximum Payment for the preceding year increased by an index based on national or local economic factors or indices;

3. The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of the Corporation, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Members upon written request;

4. An amount that has been agreed upon by a Provider and the Corporation or a member of the Blue Cross and Blue Shield Association; or,

5. An amount established by the Corporation in its sole discretion. In determining the Maximum Payment under this paragraph 5, the Corporation may, through its medical staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

Medical Child Support Order: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law), and relates to this Plan of Benefits; or

2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

3. A Medical Child Support Order must clearly specify:

    a. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order;

    b. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined;

    c. The period to which such order applies; and,

    d. Each Group Health Plan to which such order applies.

4. If the Medical Child Support Order is a national medical support notice, the order must also include:

    a. The name of the issuing agency;

b. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,

c. The identification of the underlying Medical Child Support Order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medically Necessary/Medical Necessity: means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

3. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medical Supplies: means supplies that are:

1. Medically Necessary; and

2. Prescribed by a Physician acting within the scope of his or her license (or are provided to a Member in a Physician’s office); and

3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Physician’s office and should not (in the Corporation’s sole discretion) be included as part of the treatment received by the Member); and

4. Are not prescribed in connection with any treatment or Benefit that is excluded under this Plan of Benefits.

Member: an Employee or Dependent who has enrolled under this Plan of Benefits.

Member Effective Date: the date on which an Employee or Dependent is covered for Benefits under the terms of Article II of this Plan of Benefits.

Membership Application: any mechanism agreed upon by the Corporation and the Employer for transmitting necessary Member enrollment information from the Employer to the Corporation.

Mental Health Conditions: certain psychiatric disorders or conditions defined in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits. The conditions as mandated by the State of South Carolina are:

1. Bipolar Disorder;
2. Major Depressive Disorder;
3. Obsessive Compulsive Disorder;
4. Paranoid and Other Psychotic Disorder;
5. Schizoaffective Disorder;
6. Schizophrenia;
7. Anxiety Disorder;
8. Post-traumatic Stress Disorder; and
9. Depression in childhood and adolescence.

Mental Health Services: treatment (except Substance Abuse Services) for a condition that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

Natural Teeth: teeth that:

1. Are free of active or chronic clinical decay; and
2. Have at least 50% bony support; and
3. Are functional in the arch; and
4. Have not been excessively weakened by multiple dental procedures; or,
5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above, and as a result of such treatment have been restored to normal function.

Non-Participating Provider: any Provider who does not have a current, valid Participating Provider Agreement with the Corporation or another member of the Blue Cross and Blue Shield Association.

Non-Preferred Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Drugs and has not been chosen by the Corporation or its designated Pharmacy Benefit Manager to be a Preferred Drug, including any Brand Name Drug with an “A” rated Generic Drug available.

Orthopedic Device: any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Orthotic Device: any device used to mechanically assist, restrict, or control function of a moving part of the Member's body.

Out-of-Pocket Maximum: the maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Member will be required to pay. The Out-of-Pocket Maximum is Coinsurance payable by the Member. Copayments and Benefit Year Deductibles may not apply toward the Out-of-Pocket Maximum (as set forth on the Schedule of Benefits).

Over-the-Counter Drug: a drug that does not require a prescription.

Participating Pharmacy: a pharmacy that has a contract with the Corporation or with the Pharmacy Benefit Manager to provide Prescription Drugs or Specialty Drugs to Members.

Participating Provider: a Provider who has a current, valid Participating Provider Agreement.

Participating Provider Agreement: an agreement between the Corporation (or another Member of the Blue Cross and Blue Shield Association) and a Provider under which the Provider has agreed to accept an allowance as payment in full for Benefits.

Pharmacy Benefit Manager: an entity that has contracted with the Corporation and is responsible for the administration of the Prescription Drug Benefit in accordance with this Plan of Benefits.

Physician: a person who is:

1. Not an:
    a. Intern;
    b. Resident; or,
    c. In-house physician; and
2. Duly licensed by the appropriate state regulatory agency as a:
    a. Medical doctor;
    b. Oral surgeon;
    c. Osteopath;
    d. Podiatrist;
    e. Chiropractor;
    f. Optometrist; or,
    g. Psychologist with a doctoral degree in psychology; and
3. Legally entitled to practice within the scope of his or her license; and
4. Customarily bills for his or her services.